DEATH: REFLECTIONS FOR NURSING CARE IN THE HOSPITAL SPACE

ABSTRACT

Objective: to reflect on the process of dying and death, in the hospital space, from the care done by the Nursing team. The keywords that guided the selection of the manuscripts were: "Death"; "Attitude Against Death"; "Nursing care"; "Hospital care" and; "Intensive Care Units". The manuscripts that discussed death and the care actions carried out by the Nursing team, at the hospital were included independently of the time frame. Method: qualitative study, type theoretical-reflexive essay. Results: the first pillar presents the conceptual dialogues about the hospital space, with the process of death and death. In the second, the conceptual findings are about death-dying in the Nursing practices performed by the Nursing staff in the hospital. Conclusion: the reflections point to a harmonious discourse between clinical language and the philosophy of ethical caring to care for the client who experiences dying and death in the hospital. The confrontation of death, by Nursing professionals was seen as a reaction of impotence, anguish, suffering, fear, failure, incapacity, guilt, denial and search for protection in the most experienced professionals. Descriptors: Death; Attitude to Death; Nursing Care.

RESUMO

Objetivo: refletir sobre o processo de morrer e morte, no espaço hospitalar, a partir do cuidado realizado pela equipe de Enfermagem. As palavras-chave que nortearam a seleção dos manuscritos foram: “Morte”; “Atitude Frente à Morte”; “Cuidados de Enfermagem”; “Assistência Hospitalar” e “Unidades de Terapia Intensiva”. Os manuscritos que discutiam a morte e as ações de cuidar, realizadas pela equipe de Enfermagem, no hospital, foram incluídos independentemente do marco temporal. Método: estudo qualitativo, tipo ensaio teórico-reflexivo. Resultados: o primeiro pilar apresenta os diálogos conceituais sobre o espaço hospitalar, com o processo de morrer e morte. Já no segundo, os achados conceituais versam sobre morrer-morte nas práticas de cuidar, realizadas pela Enfermagem, no hospital. Conclusão: as reflexões apontam para um discurso harmonioso entre a linguagem clínica e a filosofia do carinho ético para cuidar do cliente que vivencia o morrer e a morte no hospital. O enfrentamento da morte, pelos profissionais de Enfermagem, foi encarado como reação de impotência, angústia, sofrimento, medo, fracasso, incapacidade, culpa, negação e busca por amparo nos profissionais mais experientes. Descriptores: Morte; Atitude Frente à Morte; Cuidados de Enfermagem.

RESUMEN

Objetivo: reflexionar sobre el proceso de morir y muerte, en el espacio hospitalario, a partir del cuidado realizado por el equipo de Enfermería. Las palabras clave que guían la selección de los manuscritos fueron: "Muerte"; "Actitud frente a la muerte"; "Cuidados de enfermería"; "Asistencia hospitalaria"; "Unidades de Terapia Intensiva". Los manuscritos que discuten la muerte y las acciones de cuidar, realizadas por el equipo de Enfermería, en el hospital, fueron incluidos independientemente del marco temporal. Método: estudio cualitativo, tipo ensayo teórico-reflexivo. Resultados: el primer pilar presenta los diálogos conceptuales sobre el espacio hospitalario, con el proceso de morir y muerte. En el segundo, los hallazgos conceptuales versan sobre morir-muerte en las prácticas de cuidar, realizadas por la Enfermería, en el hospital. Conclusión: las reflexiones apuntan a un discurso armonioso entre el lenguaje clínico y la filosofía del cariño ético para cuidar del cliente que vive el morir y la muerte en el hospital. El enfrentamiento de la muerte, por los profesionales de Enfermería fue encarado como reacción de impotencia, angustia, sufrimiento, miedo, fracaso, incapacidad, culpa, negación y búsqueda por amparo en los profesionales más experimentados. Descriptores: Muerte; Actitud Frente a la Muerte; Atención de Enfermería.

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INTRODUCTION

The reflections supported by the theoretical plan on death and dying show that following these processes is part of the daily routine of the Nursing team in the hospital space. Caring for the dying and dying patient is subjectively felt by the Nursing team and, although the practical purpose of their activity is technical, the encounter with the patients or their relatives refers to another form of care, marked by the expressions practices of solidarity, compassion, silence, faith, peace and other inherent elements of existence that permeate relationships and flow through the environment.

In this perspective, talking about finitude mirrors life issues that, inevitably, are taken to the hospital, affecting the professionals who make up the Nursing team who dedicate themselves to care for their fellow men. Recognizing the phenomenon of death invites us to access the world through sensations, that is, those that are produced in the encounter between the Nursing professional and the forces of the world.

It involves some degree of consciousness belonging to the subject that cares, to its interiority to subjectively capture, during the actions, social meanings over the whole process of dying and death, taking into account the biological, psychological, ideological, political and institutional aspects present in the contexts.

In this aspect, the process of dying and death, under Nursing care, are considered as extremely complex problems in caring practices, because, in them, there are reflections that vary according to the diversity of contexts studied, however, felt by the professionals when they experience these caring scenes with their patients. This assertion acquires relief from the scientific recurrences in two already developed studies, that involved the care of the Nursing team, during the dying process, in advanced cancer patients.

The end-of-life (mis) encounters were crossed by different cultural, religious and, perhaps, philosophical conceptions, with which Nursing professionals actually, provide care for hospitalized patients in different age groups.

Although death is a reality widely experienced by Nursing professionals, especially, those working in hospital spaces of medium and high complexity, there is a lack of approach to the theme as a training axis for health professionals. During technical or higher education in Nursing, there is a strong appeal for aspects that concern the maintenance of life, from a strong strictly organic discourse, centered on health and its deviations.

It should be noted here: that the biological dimension present in Nursing care is not being denied, but it is believed that when clinical language can no longer handle the body, other dialogues that mobilize elements of a subjective order come into play and also deserve attention for those who wish to graduate as Nursing professionals. These dialogues stimulate reflections, which may be influenced by elements of subjectivity, and complement the clinical perspective on the Nursing professionals’ way of being, especially, when they encounter patients and their families in situations of death and death.

And in this particular encounter, mediated by the availability of the Nursing professional to identify the last necessities, of several orders, of the body that bids farewell to life, flowing languages capable of being horizontalized next to the coding of signs and symptoms of a disease. In this area, what has been perceived, in the area of Nursing, is a growth in scientific productions capable of objectifying the process of dying and death, from the meanings that come from Nursing workers before death and death.

With this elementary notion, there will be mutual resonance between the thematic dimensions, Nursing care and death, in a relationship that moves in the hospital space. That is, although the hospital is the common place, there are, specific parts that intertwine, pointing out how the care practices take place in the end-of-life scenes accompanied by the Nursing team.

Since the interest of this essay is centered on the reflections on Nursing care in the process of dying and death, the following question emerges: what are the scientific dialogues established between hospital Nursing care and the process of dying and death? To answer this question, there is no a priori plot and it is considered that is surrounded by various theoretical contours to be objectified in the form of reflections.

OBJECTIVE

- To reflect on the process of dying and death, in the hospital space, based on the care taken by the Nursing team.

METHOD

In the limitation of finding a method for this essay, one opted for the construction of reflections understood, in the philosophical...
plane, as an action by which the thought turns on itself, it investigates itself, examining the nature of its own activity and establishing the principles that the basis. It thus, characterizes critical consciousness, that is, consciousness insomuch as it examines its own constitution, its own questions.5

With regard to the creation of reflections on Nursing care contextualized with the process of dying and death, walking through the scientific databases inserted in the social and health sciences was chosen, especially: Nursing Database (BDENF), for controlling the scientific production in the area in which the reflections are being produced and Scientific Electronic Library Online (SCIELO), that allow access to complete articles.

The keywords that guided the selection of the manuscripts were: "Death; "Attitude Against Death"; "Nursing care"; "Hospital Care" and; "Intensive Care Units". The manuscripts that discussed death and the care actions carried out by the Nursing team, at the hospital were included independently of the time frame.

In addition, the selected articles had their references reviewed and new works with books and books that included the theme were included. In order to do so, it was sought, in the readings, the conceptual contributions adjusted to the process of death and death in the hospital space, having as its guiding axis, the Nursing care itself.

It is borne in mind that, in examining the nature of these phenomena, one encounters inaccuracies surrounding the inquiries. This is because the process of death and death are added to the set of phenomena considered as vague, 6 because they vary according to the contexts and clinical situations presented, before which Nursing professionals must act, decide and implement actions to care for the body that lives the process of dying or is dead. Reflecting on how Nursing professionals respond to these care situations, throughout their professional historicity in the hospital, is a daring, and, at the same time, a scientific risk (im) precisely assumed.

Thus, the option to use the term vague finds theoretical support in the sciences of the inaccurate and is understood as: an effort to find a relationship between two concepts - death and Nursing care. The situational dimension of the work is circumscribed in a scientific-philosophical essay, of understandable and provocative language, that raises the thought to the absence of definitive certainties both in the areas of the exact sciences, and in the human sciences.6

RESULTS AND DISCUSSION

To facilitate reflection, it was chosen, to organize the contents into two reflective pillars: “conceptual dialogues about the hospital space with the dying and death process” and “conceptual dialogues about dying and death in Nursing care practices”.

These two pillars are placed side by side, that present, as a point of nuclear support, the process of dying and death in interface the actions of Nursing care. Yes, there seems to be something to be discussed, at the core of these concepts, capable of affecting Nursing professionals when they perform their care in the hospital space.

During the varied care provided at various times of the day, such as medication administration, feeding, checking of vital parameters, body hygiene, patient mobilization in the bed, hearing needs and knowing patients’ stories, opportunities are opened to build dialogues that are about the process of dying and about death, fixed as memories in the Nursing professional, when those actions of care invested in life are vanished with finitude.

All illustrative caring actions, denote the intensity of exchanges, experienced by Nursing professionals in the body care. This requires, at first, to deepen the conversations with the concepts about death and dying in the hospital environment. All this discussion can be evidenced in the first reflective pillar.

• Dialogues on hospital space in the process of dying and death

Inaugurating this reflective pillar permeates the involvement of existing tensions between forms and forces within the hospital. Form, because the hospital space can be considered, for its geometrized representation, as a place where diagnoses, treatments, care and rehabilitations happen; and forces, to understand that there are the knowledge of the different areas of health coming from the professionals who care for and designed for the bodies that are cared for, diagnosed, treated, rehabilitated or can die.

To illustrate this statement a little, it is enough to remember that in everyday life, here thought of as happening inside the hospital, when one speaks of space without careful reflection, it is usually thought of the mathematical space, measurable, in its three dimensions, represented by meters and centimeters. Otherwise, it is rarely attempted that this is only a particular aspect of space and that space-force, experienced directly in
the daily life of caring, does not in any way coincide with this abstract-mathematical place.7

To these contributions, it is important to include the idea of the hospital as a world of disease, of the production of new knowledge, where scientific knowledge overlaps knowledge and experiences acquired throughout life. The technique that guides professionals to manipulate the body, hierarchy, order and routine, identification by registration number, ward, bed, pathology. It is a world so peculiarly organized that, as the patient penetrates within it, it gains another identity, that of patient.8

Certainly, the different sectors of the hospital act in a different way, encompassing environments, where clinical-propaedeutic discourse is the established language, even those characterized by the high concentration of hard technologies. The fact is that, even though it is necessary, the use of this type of technology in care, brings to the hospital a hostile appearance, especially, in the high complexity sectors, where these resources are integrated with Nursing practices, more intensely.

In this context, the debate over the process of dying and death permeates the consequence of living. Faced with the prospect of dying in the solitude of a bed of an Intensive Care Unit (ICU), under the use of stubborn therapeutic means that prolongs suffering and postpones the day of death, many still prefer to die differently or in another environment.9

From this characterization, it is important to note that the body of care, built in the hospital, is not the body of life - a body that is seen, to recognize itself, as experiencing feelings (love, hate, anger) by the disease. On the other hand, when health professionals are building this body through knowledge, they also produce this place called a hospital, which operates according to an organizing, legitimating, disciplining and knowing logic of these bodies.

It is necessary to keep enough of these dialogues, about the hospital world, to construct the intended considerations about the dying and death process and how they meet nursing professionals during health care delivery. The process of dying as well as death, are phenomena of life. Paradoxical themes: on the one hand, it seduces and inspires artists, transcending all artistic languages; on the other, it causes fear, flight, and terror. According to individual perception, it can mean absence or permanence; finitude or eternity.10

In the resonances between life, the process of dying and death, diverse conceptual conceptions emerge in which the responses of this phenomenon are felt, problematized and socially recognized, by the people, in the various social contexts and historical moments.

It happens that, every day, life surprises people with a variety of sensations. Sensations mediated by desires, experienced from the interaction of professionals with the forces present in the world. The fact is: to think that these flows can fade with death usually causes fear and fear. Hospitals, have now become the space in which the most present events of life, such as pain, suffering and death, have been combated at any cost. But since it is not possible to avoid death, it is common to ignore it, isolating it from social life and withdrawing emotionally, spiritually and psychically from both the dying person and his family.11

It seems that the meeting of the Nursing professional with the dying body alters human perception and the way of seeing things, momentarily. That's right: watching the death event often disorganizes people, that is, emotional zones are intensified and the first mechanism is to resist. Resistance characterized by the withdrawal and denial of the body that died, no matter, as well as avoiding the encounter with their relatives who are experiencing mourning. These dialogued reflections are anchored in the understanding of the careful body as complex of intensive flows, that is, a body populated by intensities, in which only they, the very intensities, pass and circulate.12

When life becomes weak, that is, the intensive flows conducive to the will to live are reduced, patient care loses its ability to react to the world, and, consequently, begins the process of dying. What we want to point out is that the loss of the flow of life in patient care can be represented by the production of meanings, that were felt and expressed by the Nursing professionals, about the process of dying and death. A kind of response induced by the event represented by emotions and feelings denouncing human potentialities and fragilities in the care provided.

Meanings on dying and death in the hospital that makes it possible to inaugurate the second reflective pillar of this essay, which concerns the conceptual dialogues derived from studies published nationally and internationally, which deal with end-of-life Nursing care.
Dialogues on dying and death in Nursing care practices

In this second reflective pillar, conceptually, dialogue ideas, about the space where the professionals that make up the Nursing team move to care and is concerned to understand that it is specifically, in the hospital, the encounter with people in the process of dying and death happens.

This is an experience that focuses, mainly, on the (micro) spaces of medium and high complexity, where the end of life is daily the center of discussions and objects of professional practice. In this perspective, Nursing workers end up assuming a prominent position, basically, due to the close relationship established with care patients.

A fact justified by the Nursing team to be present, in hospitals, 24 hours a day, performing various care actions, thus having the opportunity to know the existential meaning of illness, the demands and desires for health promotion, protection and recovery practices as well as, the main necessities before the process of dying-death.13

Thus, it is necessary to say what care is being spoken, and what Nursing care is, in order to foster the multidisciplinary dialogues that deal with the process of dying, death and its related themes. To the extent that it is qualified, there is a concern in knowing what elements are in this qualify that they are able to amplify what has been said in the improvement of the professionals in the daily work and in the academic formation of Nursing, especially, when the end of the life becomes, the central element in professional know-how.

In this way, the scientific productions incorporate, in the routine of Nursing care, a process of adjectivation and qualification of the term care. Gradually, the care developed by Nursing is subjected to a strong interference with several slogans, which illustratively highlight: palliative, ethical, holistic, human, sensitive, among others.

These conceptual natures are not excluded, however, it is worth noting that, above all, the care that is interested in this reflection, in communion with the process of dying and death is Nursing, understood as: an unconditional action of the professional led by impulses of love, hate, joy, pleasure, hope, despair, energy to touch, manipulate moods and odors; it is a liberating act that represents the human essence, that is charged with emotion and possibility of keeping the other free; it is a political action and can be revolutionary because its event can break with the past, with what is established as care, and make the subjects involved in their own actions.

Unconditional action, since, in the majority of hospital deaths, there is, at least, one Nursing professional next to the body being cared for, regardless of the medical diagnosis, clinical condition, stage of death experienced by the patient or, even, after its finding physiological. There, Nursing mobilizes a set of inner impulses that, are essentially, of a subjective order, to provide during health practices: reception, relief, comfort and preservation of a dignified death.

The meaning of care for a good death runs through the promotion of comfort to the person at the end of life, and the Nursing professional should not have, as a parameter, what he wants for himself, but respect what the person needs and desires, even listening, to the family, when she cannot express herself. It must be remembered that one person is never the same as the other, although the clinical manifestations of the disease may have the same characteristics.13

It is important to note that, in this interrelated relationship between life and death, represented by the Nursing professional, who dispenses care, mainly, for the maintenance of life and the patients who are cared for during the process of dying, there are unusual and singular elements that can approach, in greater or less intense care, to the actual needs at the time of death. Well, on the one hand, the Nursing practices, that take place in hospital spaces, involve and, at the same time, are involved in a language strictly focused on identifying the signs and symptoms that cohabit the patient's body that experiences the stages of death.

This careful body is populated by contents that talk about illnesses or their absence and is configured, in the field of health, as a territory dominated by the medical-centered view, which establishes in a hegemonic way, a conception of caring, whose principle lies in language clinic. It is in the clinic the exact location of the diseases whose bearer is indifferent: what is present is the illness in the body that is its own, which is not the patient, but that of his truth. It is the different diseases that serve as text; the sick person is just that through which the text is presented to the reading and sometimes complicated and confused.15

In this understanding, the process of dying and death are underlined as capable of inaugurating, on the other hand, speeches that run parallel to the clinic. A philosophical language conceptually referred to, as ethical
affection, is incited here. The philosophy of ethical affection puts the most scientific data on the subject in perspective, while insisting on the complex and innovative aspect of the relationship with the other, at the exact moment when the sick person is no longer comprehensible through a concept resulting from clinical analysis, especially, at the end of life.\textsuperscript{16}

Guided by this important philosophical contribution, that provides light to our conversations, that is included the relational dimension in the daily care of Nursing. During the process of dying and death, it is necessary to take care, in a perspective that focuses the patient as a person, aiming at the patient's comprehension in its complexity: life history, culture, occupational, occupational structure, affectivity and spirituality.\textsuperscript{17}

In this particular relationship of care, the ethical affection is structured. Language of respect, of responsibility, but, also, of deciphering, analysis, interrogation (between saying and saying). Two languages can thus cohabit and articulate without confronting each other: the clinical view, that conceptualizes the patient's body, in sickness and the ethical affection, that establishes a new way of relation with the other, researching what is not conceptualizable, which is strange to pathology, but competes for well-being, which tries to listen to the unspeakable and see the invisible. Fundamentally, the ethical affection induces the Nursing to question the values that it defends, on the ethics of its acts. Ethical affection does not want to nullify the need for the clinical view, it fundamentally completes it.\textsuperscript{16}

At the end of the life of the patient care, the technical knowledges in health and the clinical speeches are horizontalized to a potent subjective, field characterized by the intensification of shares that portray emotions and feelings. It is at this moment that the members of the Nursing team, when caring for the end-of-life, refer to difficulties in coping with death, especially, early in life. The qualitative findings, from highly complex units, indicate that workers do not feel psychologically prepared, because the training has left out questions about death.\textsuperscript{18}

Without pretending to give recipes or easy answers to professionals who work in Nursing, it is important to base the training on the death axis in the following points: sensitization of students to feelings and reflections on various aspects related to the subject, such as: mourning, suicide, dying with dignity, requests to die, living wills, non-

implantation or non-maintenance of treatments for the purpose of prolonged life, euthanasia, dysthanasia, assisted suicide, sedation, use of analgesia, among others.\textsuperscript{19,20}

In addition, the discussion of the themes related to dying and death, in technical or higher Nursing education, regardless of the pedagogical strategy used and must be traced by elements of the lived practice. A kind of learning that will involve cognitive and affective aspects, seeking the individual and collective sense of the phenomenon. It is to be able to make a constant review of the theme of death, in the academic stage, examining conflicts, frustrations and taking into account the apprentice's point of view in the construction of knowledge itself.\textsuperscript{19}

It is quite certain, by the volume of scientific production, that death is part of the routine of Nursing workers. It is surely impossible, not to talk about it when the team begins to present distress and difficulties to deal with the news of death in the hospital care space. No one walks unscathed against the prospect of an unavoidable end, regardless of who the person is at risk of dying. When this possibility arises from illness or accident, in which the individual remains hours, days or even months at the mercy of continuous care, the proximity of death is reverberated even more complex, even among those professionals more experienced or properly prepared for these confrontations.\textsuperscript{10}

The studies consulted show that the meanings related to the process of dying and death, for Nursing professionals, were guided by feelings, of which the following are highlighted: impotence, anguish, suffering, fear, which interfere with the care provided to the patient and his family.\textsuperscript{2,21,22}

Some findings reveal that nurses who understand death as failure. As much as one hopes for the success in the care, when this has its end with the death of the patient, the sensation is of incapacity and fault.\textsuperscript{23,24}

Also, included, in the selected works are reflections of Nursing professionals who do not feel prepared to take care of the patient at the end of life. To do so, they align themselves with experienced colleagues and support their strategies in moral, ethical, and religious precepts.\textsuperscript{18,25}

Specifically, the coping of death by members of the Nursing technical team of a school hospital in the interior of the State of São Paulo was considered by the maintenance of minimal care, based on the religious conception that death is a design of God and not of man. In addition, when physicians make
the decision not to invest in resuscitation procedures, the Nursing team adopts the psychological attitude of detachment, that is, they remain indifferent and emotionally distant, from the family to ease the suffering.18

Despite the (dis) beliefs of Nursing professionals and their expression in hospital care, to patients experiencing death, but there are certain people, who do not believe in God. In this sense, it is important to bring to reflection the forms of coping with death, that are determined by spirituality, in clinical practice.

Until now, Brazilian Nursing professionals have named spirituality as something that is felt, not seen, and cannot be touched. It is sustained, in the human plane, when belief, faith, joy, sensitivity, love, hope, solidarity, tolerance and detailed attention to the culture and religion of each one of us and of those they care for, were expressed; attention to the history and memory of professional’s and the patient’s lives in caring encounters.25

The articles selected allowed nurses to analyze the concealed death, that is, the one that, however much happens, is denied, concealed and concealed. The significance of death, involving concealment, is perceptible when professionals portray the hospital space and their professional performance. In this sense, what comes into play, during the care of the patient in the process of dying and death, is the professional influence acquired in the units of high complexity.24,26

At the end of this reflective pillar, it is opportune to reflect on the terms “terminality process,” “terminal phase,” “terminal patient,” “terminal patient,” and “terminal assistance” so present in the manuscripts dealing with death and death.

In fact, the words mentioned are quite broad and diversified. However, this semantic diversity is related to the different institutions their philosophies and therapeutic proposals. In some institutions, that treat patients with a diagnosis of incurable disease, the term can be applied from the moment of the diagnosis, although the patient does not present any symptoms of the disease. In these places, the idea of terminality covers a longer period, and care involves helping the patient to accept his own finitude, prepare for death and say goodbye to life.

In other institutions, that receive patients in their final moments, they deal with the idea of terminality more narrowly, referring to the moments of the end of life. In these places, the patient is careful not to feel pain, and the actions of caring turn to minimize their suffering and their relatives at the moment of death. Thus, it is possible to perceive that the different conceptualizations of the terms are related to the way care is defined and administered in different institutions.

For us authors, the term “terminal” causes strangeness. This is because this slogan has a diversity of meanings. In this essay, the term was understood to be the person who is in the final stage of an illness, thus, close to death.27

There is a pause to think: after the patient's death is physiologically verified, by the absence of heart beats and respiratory incursions inside the caring scenes, which usually portray the efforts of the health team to maintain life, the only protagonists that remain beside of the bed, are the Nursing professional and the dead body. At that moment, Nursing faces the lifeless body and seems not to be salutary, pleasing to the eye, to the senses, to manipulate a corpse, to wipe and to clean its body damp of secretions, to tamp with cotton its orifices before intact. It is a confrontation with death, it is the denial of life, it is the loss of a patient, it is the denial of the profession, of the actions previously employed, of the care rendered, it is the lost challenge.28

At that moment, the mortal body, a Nursing work instrument, can generate, in the professional, sadness during the preparation of the body, that is strongly associated with the established bond, the time of professional experience and the presence of intense emotions experienced with the patient.29 Nursing care remains objectified in the preparation of the dead body and the patient remains the center of caring actions. Here, it is evident the clear overlap of the binomial that was invested in decoding efforts: Nursing care and body.

The body, even after death, remains as a historical materialization for Nursing professionals. Often, what remains is the memory about the person, who was, as it seemed, behaved, what he spoke and other peculiarities that constituted his identity as patient care. Although some of these aspects are pertinent to the body, sex, height, physical constitution, physiognomy, among others; such traits are usually mediated by the intellectual, emotional, and behavioral attributes that characterize human beings.

In this aspect, it is understood as a place of representations, expression, creation and production of images. Power and products of subjectivities; established and instituting. Real-emotional body (objective and
subjective). Body-memory, because it is what is remembered. Thus the body is flesh-memory, ethical, living, pulsating, flesh-blood, origin and end of the culture created. 10

It is in these conceptual dimensions that Nursing care does not end after the discovery of death, and therefore, it is challenging, since it can be crossed by a multiplicity of (bio) ethical questions. In this sense, it is useful to affirm that the process of dying, death and postmortem are distinct steps that the Nursing professional takes when taking care of patients in the hospital.

CONCLUSION

Embarking on this reflection, about the process of dying and death in the hospital space, from the care done by the Nursing team, was tied to different theoretical conceptions that refers to what is understood as the end of life and how this understanding gains forms in the daily actions of caring . We found terms and phrases that are in the history of the sciences and the Nursing profession itself, and, that are hardly measured by the criteria and requirements of the hard sciences.

Inaccuracy arising from the most diverse situations of care at the end of life, experienced by Nursing, in which the professional needs to make decisions. The analyzed works point to dialogues for the Nursing care that was revealed in a harmonious discourse between the clinical language and the philosophy of the ethical affection, to take care of the patient who experiences the process of dying and death. Therefore, it is necessary to think about all these stages, the process of dying - death - after death, as objects of studies, in Nursing investigations. The great majority of the articles selected showed that the Nursing professional, in meeting the patient in those circumstances, reacts by facing death with feelings of impotence, anguish, suffering, fear, failure, that interfere with the care provided to the patient and their family.

In addition, Nursing professionals, faced with the death phenomenon, especially in environments of high complexity, seek support in more experienced professionals, in the discourses of the technified environment and in the religious conceptions, thought, in close relation, with the expressions of spirituality in the practices of caring . The body at the end of life was not understood as terminal, but rather as a continuity of care provided by the Nursing team in the hospital space. It is hoped, with future aims, that these dialogued reflections arouse the curiosity and the desire for the maintenance of new scientific adventures in the Nursing area and, as contribution, it is suggested the adoption of studies, in hospital scenarios, with the inclusion of philosophical elements and (bio) ethics.

REFERENCES

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